Screening Quality Assurance visit report

NHS Breast Screening Programme
Barnsley Hospital NHS Foundation Trust

17 October 2019
About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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About PHE screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the 4 UK countries. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

www.gov.uk/phe/screening Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

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Contents

About Public Health England 2
About PHE screening 2
Executive summary 4
  Quality assurance purpose and approach 4
  Local screening service 4
  Findings 5
Recommendations 7
  Governance and leadership 7
  Infrastructure 10
  Identification of cohort 13
  Invitation, access and uptake 13
  The screening test – accuracy and quality 14
  Referral 15
  Diagnosis 15
  Intervention and outcome 16
  Next steps 18
Executive summary

The NHS Breast Screening Programme aims to reduce mortality from breast cancer by findings signs of the disease at an early stage.

The findings in this report relate to the quality assurance visit of the Barnsley Breast Screening Programme (BSP) held on 17 October 2019.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in breast screening. This is to make sure that all eligible people have access to consistently high-quality service wherever they live. QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider, commissioner and external organisations
- information collected during pre-review visits
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Barnsley Breast Screening Service (BBSS) functions in the geographic area of the NHS Barnsley Clinical Commissioning Group. It has an eligible screening population (ages 47 to 73) of around 45,000 people.

The current¹ screening cohort for women aged 50 to 70 years is 35,679 invited to screening over a 3-year period. The numbers of women in the age extension trial (women aged 47 to 49 and 71 to 73) are 5,758 and 4,434, respectively.

One assessment clinic is run per week and there are no mobile screening units. The area covered includes areas of high deprivation and small numbers of ethnic minority populations. For more information please refer to the programme management and governance section of this report.

The service offers all aspects of high-risk screening.

¹ Source: NHS Digital 2019
Findings

Immediate concerns

The QA visit team identified 2 immediate concerns. A letter was sent to the chief executive on 18 October 2019, asking that the following items were addressed within 7 days:

- critical lack of resilience in staffing
- the requirement to use 2 separate picture archiving and communications systems (PACS)

A response was received and actions have been taken to partially mitigate the immediate risks within the programme. Follow up of the completion of these actions should be included within the QA visit action plan (see recommendations 10, 11, 12, 17, 19 and 24).

High priority

The QA visit team identified 10 high priority findings as summarised below:

- no protected time for DoBS to complete the duties and responsibilities for the role
- lack of staff training in reporting incidents and monitoring of incidents on Datix
- many standard operating procedures (SOPs) are not in line with national guidance
- shortfall in radiography, radiology, pathology staff; and potentially administration staff
- sustainability of the service due to the absence of key staff
- no business continuity plan for breast screening, which should include PACS migration to new PACS system, IT disaster recovery, succession planning, staff cover arrangements and process for equipment replacement
- PACS system does not permit simultaneous viewing of current and previous images
- MRI scans are not double reported
- bespoke in-house training for the assistant practitioners requires confirmation of accreditation by the Society of Radiographers
- a breast care nurse is not present in each assessment clinic
Shared learning

The QA visit team identified several areas of practice for sharing, including:

- consistent engagement in the QA process
- staff demonstrate dedication to the service and the team, with a clear patient focus
- the medical physics department provides a monthly round-up of routine quality assurance
- patient dose audit takes place on an annual basis, which exceeds the NHSBSP recommended frequency of 3 yearly audit
- comprehensive monitoring of high-risk women requiring MRI
- development of in-house training for assistant practitioners
- good scope of practice documentation for advanced practitioners and assistant practitioners
- comprehensive supporting documentation for the Eklund technique
- pathology department has regular audit of practice and good internal quality control
- Barnsley Prevention and Early Diagnosis Steering Group has a comprehensive action plan and mechanisms in place to monitor the effectiveness of engagement work
Recommendations

The following recommendations are for the provider to action unless otherwise stated.

Governance and leadership

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<thead>
<tr>
<th>No.</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>CBA1901</td>
<td>The director of breast screening (DoBS) should present this QA visit report and key risk issues at a trust board meeting</td>
<td>(1)</td>
<td>6 months</td>
<td>Standard</td>
<td>Trust board meeting minutes and action log feedback receipt</td>
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<tr>
<td>CBA1902</td>
<td>Commissioner and provider to ensure that the appropriate governance mechanisms are in place across the whole of the programme in relation to sub-contracts</td>
<td>(1)</td>
<td>6 months</td>
<td>Standard</td>
<td>Confirmation of process</td>
</tr>
<tr>
<td>CBA1903</td>
<td>Ensure the job plan for the DoBS offers protected time to complete the duties and responsibilities for the role</td>
<td>(2)</td>
<td>3 months</td>
<td>High</td>
<td>Trust-approved job description</td>
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<tr>
<td>CBA1904</td>
<td>Complete a training needs assessment and training programme for both programme managers and administration staff on all relevant data entry/administrative processes to include;  - Using BSIS  - BS Select  - Clinical data inputting  - Registration of high-risk women</td>
<td>(2)</td>
<td>6 months</td>
<td>Standard</td>
<td>Training plan and training log</td>
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<td>• Ceasing women under the Mental Capacity Act and bilateral mastectomy</td>
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<td>1. Local incident management policy</td>
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<td>2. A one-off Datix report showing 6 months of submissions (Datix period 1 November 2019 to 30 April 2020)</td>
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<td>3. Training log</td>
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<td>CBA1905</td>
<td>Review the local incident management process and supporting trust policies, to ensure • consistency with national guidance and timely reporting of incidents • all staff are trained in completing a screening incident assessment form</td>
<td>(3)</td>
<td>3 months</td>
<td>High</td>
<td></td>
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<td>CBA1906</td>
<td>Review and update quality management system (QMS) to include all standard operating procedures (SOPs), work instructions and version control of each document. Ensure this is included in the annual QMS audit</td>
<td>(4)</td>
<td>3 months</td>
<td>High</td>
<td>Updated QMS approved by the management meeting with an annual audit schedule</td>
</tr>
<tr>
<td>CBA1907</td>
<td>The commissioner should agree with the provider an annual schedule of audits</td>
<td>(1)</td>
<td>6 months</td>
<td>Standard</td>
<td>Confirmation that the methodologies, objectives and reporting mechanisms have been agreed at an MDT meeting and copy of the schedule for the first 12 months</td>
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<tr>
<td>CBA1908</td>
<td>Progress completion of the recommendations made during the right results walkthrough of 31 July 2019</td>
<td>(4)</td>
<td>6 months</td>
<td>Standard</td>
<td>Action log</td>
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| CBA1909 | Produce an annual report 2018/2019 and present this to the relevant trust and programme boards | (1)       | 6 months  | Standard | 1. Annual report  
2. Minutes of meetings where report was presented |
## Infrastructure

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| CBA1910 | Review current staffing levels, workload and skill mix. Create and implement a succession plan to ensure current and future capacity meets demand for all disciplines. To include:  
  - a skill mix review to address the vulnerability of the advanced practice, training and mammography leadership within the service  
  - 0.91 WTE shortfall of radiographers  
  - appropriate programme manager supervision of clinical areas  
  - support for all management responsibilities  
  - review of administrative staffing structure  
  - WTE shortfall of consultant radiologists and 2 unfilled pathology consultant posts  
  - support to the QA radiographer  
  - review of WTE to take on stereotactic biopsy  
  - protected time to carry out training  
  - timely recording of interval cancers on NBSS | (1), (4), (5), (14), (15) | 3 months  | High     | 1. A detailed workforce and implementation plan, identifying staff requirements for all disciplines  
2. Action plan to address the shortfall  
3. Training plan for newly appointed backfill for programme manager (clinical areas)  
4. Identified support for all management responsibilities  
5. Administrative staffing review  
6. Action plan to address the shortfall  
7. Identified support  
8. Action plan to ensure sustainability  
9. Training log  
10. Action plan to address the backlog |
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</table>
| CBA1911 | Develop and implement a service business continuity plan to include all disciplines delivering breast screening, to include:   | (1), (15) | 3 months    | High     | 1. Business continuity plan with agreed implementation plan  
2. Service delivery improvement plan |
    | • mitigating risk to service delivery during the PACS migration  
• IT disaster recovery (including National Breast Screening System (NBSS))  
• succession planning  
• staff cover arrangements  
• process for equipment replacement |
| CBA1912 | Ensure the equipment, accommodation / premises in use throughout the service meets the specification, guidance and needs of service users | (1)       | 9 months    | Standard | Risk assessment done and action in place; to action plan closed                  |
| CBA1913 | Review, monitor and ensure that symptomatic services do not compromise screening service delivery | (5), (6)  | 3 months    | Standard | 1. Minutes of programme board discussion and assurance provided  
2. Detailed workforce plan, identifying staff requirements for symptomatic and screening service delivery |
<table>
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</table>
| CBA1914 | Produce written protocols for  
  • returning equipment to clinical use and the required QC checks  
  • inputting histology of interval cancer cases. | (7), (2)  | 6 months  | Standard | Protocols                          |
| CBA1915 | IRMER procedures should be adapted to reflect practice in NHSBSP accurately | (8)       | 3 months  | Standard | Updated procedure                  |
| CBA1916 | Review User QC processes to  
  • produce a written protocol for testing of the stereotactic kit  
  • ensure the roles and accountabilities of the QA radiographer are set out in writing.  
  • establish communication between the QA radiographer and the MR Superintendent, with QC records shared | (9), (5)  | 6 months  | Standard | 1. Protocol  
  2. Trust approved job description  
  3. Protocol |
| CBA1917 | Review PACS processes:  
  • complete a risk assessment of the current PACS system and imaging viewing  
  • develop and implement a risk-assessed action plan for the transition to the new PACS system | (10), (15)| 3 months  | High     | 1. Risk assessments and action plans done and action in place; to action plan closed.  
  2. Time lined action plan in place; to action plan closed. |
## Identification of cohort

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<tr>
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</table>
| CBA1918 | Review administration processes to ensure  
• meetings have a set agenda.  
• complaints and non-conformance are discussed at staff meetings. | (1)       | 6 months  | Standard | 1. Agenda 2. Minutes             |
| CBA1919 | Review radiology processes to ensure  
• MRI scans are double reported | (10)      | 3 months  | High     | Confirmation of compliance      |

## Invitation, access and uptake

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<tbody>
<tr>
<td>CBA1920</td>
<td>The commissioners and stakeholders should develop an action plan to improve uptake</td>
<td>(11), (12)</td>
<td>6 months</td>
<td>Standard</td>
<td>1. Action plan 2. Health promotion strategy</td>
</tr>
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# The screening test — accuracy and quality

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</table>
| CBA1921 | Review radiography processes to ensure:                                          | (5)       | 6 months  | Standard | 1. Protocol  
2. Protocol with confirmation of compliance  
3. Charts of repeat rates for individual mammographers over 3-month periods  
4. Evidence of feedback, training and development provided, if applicable |
|         | • regular reviews of individual image quality; with feedback and identification of educational and development needs provided to the individual to promote learning.  
• individuals perform a personal audit of a minimum of 20 sets of imaging every 2 months.  
• monitor repeat rates over a rolling 3-month period for individual mammographers. Feedback, training and development to be provided to individuals with a high repeat rate and documented with associated actions plans when necessary. |           |           |          |                                                                                  |
| CBA1922 | Confirm that the bespoke in-house training for the assistant practitioners will be accredited by the Society of Radiographers | (5)       | 3 months  | High     | Confirmation from the Society of Radiographers                                    |
### Recommendation

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</table>
| CBA1923 | Review radiology processes to ensure:
  - regular reviews of individual film reading to prevent outliers
  - cases with calcification are managed according to national guidelines
  - B3 lesions are managed in line with national guidance.
  - review of cases that are discharged from assessment clinic without biopsy. | (10)      | 6 months  | Standard | 1. Action plan  
2. Protocols and confirmation of compliance |

### Action plan

1. 
2. 

### Protocols and confirmation of compliance

### Referral

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<tbody>
<tr>
<td>CBA1924</td>
<td>Ensure service routinely meets date of first offered assessment (DOFOA) and date of assessment (DOA) key performance indicators</td>
<td>(1)</td>
<td>3 months</td>
<td>Standard</td>
<td>Action plan</td>
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### Diagnosis

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<tbody>
<tr>
<td>CBA1925</td>
<td>A breast care nurse (BCN) must be present in each assessment clinic</td>
<td>(11)</td>
<td>3 months</td>
<td>High</td>
<td>Audit of compliance</td>
</tr>
<tr>
<td>CBA1926</td>
<td>Ensure implementation of tomosynthesis</td>
<td>(1)</td>
<td>9 months</td>
<td>Standard</td>
<td>Action in place; to action plan closed</td>
</tr>
<tr>
<td>CBA1927</td>
<td>Review false negatives</td>
<td>(10)</td>
<td>9 months</td>
<td>Standard</td>
<td>Protocol and audit of compliance</td>
</tr>
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### Screening Quality Assurance visit report: NHS Breast Screening Programme

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<tr>
<td>CBA1928</td>
<td>Ensure screening cases can be differentiated from non-screening cases</td>
<td>(14)</td>
<td>9 months</td>
<td>Standard</td>
<td>Audit period 1 November 2019 to 30 April 2020</td>
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<tr>
<td>CBA1929</td>
<td>Audit breast core biopsy results with particular attention to B1 cases.</td>
<td>(14)</td>
<td>9 months</td>
<td>Standard</td>
<td>Audit period 1 November 2019 to 30 April 2020</td>
</tr>
<tr>
<td>CBA1930</td>
<td>Audit ER positive tumours to check ER positive rates</td>
<td>(14)</td>
<td>9 months</td>
<td>Standard</td>
<td>Audit period 1 November 2019 to 30 April 2020</td>
</tr>
</tbody>
</table>
| CBA1931| Review pathology processes to ensure                                               | (14)      | 9 months  | Standard | 1. Action plan  
|        | • number of cancer resections reported by each consultant is monitored           |           |           | 2. Attendance record                                                               |
|        | • pathologists attend at least 1 regional QA meeting each year                  |           |           | 3. Confirmation of compliance                                                      |
|        | • the cut-up protocol for sentinel lymph nodes adheres to NHSBSP guidelines     |           |           |                                                   |

### Intervention and outcome

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<tbody>
<tr>
<td>CBA1932</td>
<td>Access to a psychologist should be available, if required</td>
<td>(11)</td>
<td>6 months</td>
<td>Standard</td>
<td>Confirmation of compliance</td>
</tr>
<tr>
<td>CBA1933</td>
<td>Review MDT meeting processes to ensure attendees sign in</td>
<td>(1)</td>
<td>6 months</td>
<td>Standard</td>
<td>MDT sign in sheets for period 1 November 2019 to 30 April 2020</td>
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<tr>
<td>No.</td>
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<td>CBA1934</td>
<td>Surgeons and pathologist to audit accuracy of the 2018 to 2019 data inputted into the ABS database, performed by the office admin team</td>
<td>(1)</td>
<td>6 months</td>
<td>Standard</td>
<td>Outcome of audit</td>
</tr>
</tbody>
</table>
Next steps

The screening service provider is responsible for developing an action plan with the commissioners to complete the recommendations of this report.

SQAS will work with commissioners to monitor activity and progress in response to the recommendations made for a period of 12 months after the report is published. Following this, SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline further actions, if needed.